C. This plan shall have an effective date of October 1, 1981 (Updated July 1, 1982), at which time hospital prospective reimbursement rates shall be established for the remainder of the applicable hospital fiscal year for 1982 or 1983.

D. For succeeding years, all hospitals with fiscal years that end in the months of January through June will have their inflation index trended forward to a common fiscal year-end of June 30. Their Title XIX per-diem rate will be established in July for services beginning on July 1. All hospitals with fiscal years that end in the months of July through December will have the inflation index trended forward to a common fiscal year-end of December 31. Their Title XIX per-diem rate will be established in January for services beginning January 1.

1. The trended forward inflation factor used in I.D. shall be equal to one-twelfth (1/12) of the annual trend factor projection for each month the Medicaid rate adjustment is delayed by provisions of this subsection.

2. This trend factor adjustment shall be in addition to the twelve (12) month index base period adjustment.

E. Six months after the hospital's Title XIX per-diem rate has been established, under provisions of subsection I.A., the rate shall be reviewed and compared to the most current Title XVIII Medicare rate on file with the Missouri Division of Medical Services as of the review date. At this time a redetermination shall be made under the provisions of subection I.A. as to the Title XIX per-diem rate applicable to the individual hospital and to be effective during the six (6) months subsequent to the review and through the next following June 30 or December 31. This provision shall apply only to those facilities reimbursed on a per-diem methodology by Medicare.

F. The inflation index will be developed by the Missouri Division of Medical Services using as guidelines, the National Hospital Input Price Index methodology. The method includes forecasted and historical data as developed by Data Resources, Inc. (DRI, Cost Forecasting Services, Regional Forecasting Models for Selected Components of the Hospital and Nursing Home Cost Index, 1750 K Street, Washington, D.C. 20006), and appropriate HCFA weights (Exhibit A). The hospitals will be notified as to the amount of each index used to calculate their Title XIX per-diem rate.

Effective October 1, 1981 for determination of the providers' Title XIX per-diem rates during the state's fiscal year 1982, the Missouri Hospital Market Basket Indices, which included the 1% intensity allowance, were 11.01% for FY 80, 10.28% for FY 81 and 10.56 for FY 82.

Effective July 1, 1982 for determination of the providers' Title XIX per-diem rates during the state's fiscal year 1983, the Missouri Hospital Market Basket Indices, which included the 1% intensity allowance, were 13.2% for FY 81, 9.13% for FY 82, and 7% for FY 83.

Effective July 1, 1983 for determination of the providers' Title XIX per-diem rates as determined in (1)(A)1. and (1)(A)3. during the state's fiscal year 1984, the Missouri Hospital Market Basket indices, which included the 1% intensity allowance, were 11.46% for FY 1982, 7% for FY 1983 and 7% for FY 1984. The 1984 Missouri Hospital Market Basket Index of seven percent (7%) was applied in the following manner:

1. An increase applied to each individual provider's per-diem rate equal to three and one-half percent (3.50%); and

2. An increase applied to each individual provider's per-diem rate equal to three and one-half percent (3.50%) times the average weighted per-diem rate paid for all hospitals as of June 1, 1983.

Effective July 1, 1984 for determination of the providers' Title XIX per-diem rates as determined in 1(A)1. and (1)(A)3. during the state's fiscal year 1985 the Missouri Market Basket indices, which include the 1% intensity allowance, are 7% for FY 1983, 6.12% for FY 1984 and 6.41% for FY 1985. The 1984 and 1985 Missouri Hospital Market Basket Indices shall be applied in the same manner as identified in the preceding paragraph for the 1984 FY Market Basket Index.

Effective July 1, 1985 for determination of the providers' Title XIX per-diem rates as determined in (1)(A)1. and (1)(A)3. during the state's fiscal year 1986, the Missouri Market Basket indices, which include the 1% intensity allowance, are 6.12% for FY 1984, 4.95% for FY 1985 and 4.42% for FY 1986. The 1986 Missouri Market Basket Index of 4.42% shall be applied in the following manner:

1. An increase applied to each individual provider's per-diem rate equal to two and twenty-one hundredths percent (2.21%); and

2. An increase applied to each individual provider's per-diem rate equal to two and twenty-one hundredths percent (2.21%) times the average weighted per-diem rate paid for all Missouri hospitals, excluding state mental health facilities, as of June 1, 1985.

Effective July 1, 1986 for determination of the providers' Title XIX per-diem rates as determined in (1)(A)1. and (1)(A)3. during the state's fiscal year 1987, the inflation indices are 4.95% for FY 1985, 3.86% for FY 1986, and 3.8% for FY 1987. The 1987 inflation index of 3.8% shall be applied in the following manner:

1. An increase applied to each individual provider's per-diem rate equal to one and nine-tenths percent (1.9%); and

2. An increase applied to each individual provider's per-diem rate equal to one and nine-tenths percent (1.9%) times the average weighted per-diem rate paid for all Missouri hospitals, excluding state mental health facilities, as of June 1, 1986.

Effective July 1, 1987 for determination of the providers' Title XIX per-diem rates as determined in I.A.1. and I.A.3. during the state's fiscal year 1988, the inflation indices are 4.09% for FY 1986, 3.17% for FY 1987, and 2% for FY 1988. The 1988 inflation index of 2% shall be applied in the following manner:

1. An increase applied to each individual provider's per-diem rate equal to one percent (1%); and

2. An increase applied to each individual provider's per-diem rate equal to one (1%) times the average weighted per-diem rate paid for all Missouri hospitals, excluding state mental health facilities, as of June 1, 1987.

Effective January 1, 1989, for the determination of providers' Title XIX per-diem rates as stated in paragraph I.A.I. and I.A.3. during the state's fiscal year 1989, the following inflation indices will be applied: three and seventeen hundredths percent (3.17%) for fiscal year 1987; two percent (2%) for fiscal year 1988; and one percent (1%) for fiscal year 1989. The 1989 inflation index of one percent (1%) shall be applied in the following manner:

1. An increase applied to each individual provider's per-diem rate equal to one-half of one percent (.5%); and

2. An increase applied to each individual provider's per-diem rate equal to one-half of one percent (.5%) times the average weighted per-diem rate paid for all Missouri hospitals, excluding state mental health facilities, as of June 1, 1988.

Effective July 1, 1989, for the determination of providers' Title XIX per-diem rates as stated in paragraph I.A.I. and I.A.3. during the state's fiscal year 1990, the following inflation indices will be applied: two percent (2%) for fiscal year 1988; and one percent (1%) for fiscal year 1989; and one and one-half percent (1.5%) for fiscal year 1990. The 1990 inflation index of one and one-half percent (1.5%) shall be applied in the following manner:

1. An increase applied to each individual provider's per-diem rate equal to one-half of one percent (.75%); and

2. An increase applied to each individual provider's per-diem rate equal to one-half of one percent (.75%) times the average weighted per-diem rate paid for all Missouri hospitals, excluding state mental health facilities, as of June 1, 1989.

G. Should a change occur in the inflation index, these changes will be applied to subsequent yearly prospective rates and shall not increase or decrease a hospital's Title XIX reimbursement rate during the current fiscal year.

H. The Title XIX per-diem rate as determined by this plan shall apply only to services furnished to recipients whose date of admission occurs after this plan's effective date.

II. Definitions

A. Effective Date

1. The Plan Effective Date shall be October 1, 1981.

2. The Adjustment Effective Date shall be thirty (30) days after notification to the hospital that their reimbursement rate has been changed unless modified by other sections of the plan.

B. Base Year Rate

The base year rate shall be the Title XIX per-diem rate as determined by the individual Hospital Cost Report for the third prior Hospital Fiscal Year.

C. Medicare Rate

The Medicare Rate is the rate established on the basis of allowable costs as defined by applicable Medicare standards and principles of reimbursement (42 CFR Part 405) as determined by the servicing fiscal intermediary based on yearly Hospital Cost Reports.

D. Cost Report

A cost report details, for purposes of both Medicare and Medicaid reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing said cost report.

E. Allowable Costs

Allowable costs are those defined as allowable in 42 CFR, Chapter IV, Part 405, subpart D, including routine cost limits as specified in 42 CFR 405.460, except as specifically excluded or restricted in this plan. Penalties or incentive payments as a result of Medicare target rate calculations shall not be considered allowable costs. Implicit in any definition of allowable cost is that such cost is allowable only to the extent that it relates to patient care; is reasonable, ordinary and necessary; and is not in excess of what a prudent and cost-conscious buyer pays for the given service or item.

F. Non-Reimbursable Items

For purposes of reimbursement of reasonable cost, the following are not subject to reimbursement:

1. Allowances for return on equity capital for non-profit hospitals; and

2. Amounts representing growth allowances in excess of the intensity allowance, profits, and/or efficiency bonuses.

G. Reasonable Cost

The reasonable cost of inpatient hospital services is an individual hospital's Medicaid per-diem cost per day as determined by dividing allowable Medicaid inpatient costs by total Medicaid inpatient days including nursery days.

H. Trend Factor

The trend factor is a measure of the change in costs of good and services purchased by a hospital during the course of one (1) year.

I. Intensity Allowance

An intensity allowance, to permit growth in the level of care normally received by inpatient hospital recipients, for fiscal year 1985 and 1986 will be applied to all hospitals.

III. Per-diem Reimbursement Rate Computation

A. The Title XIX per-diem for a hospital's fiscal year shall be determined using the applicable base year Medicaid cost report. These reports will be reviewed and each hospital's per-diem rate will be determined and adjusted as follows:

1. Allowable inpatient routine and special care unit expenses, ancillary expenses, and other applicable costs will be added to determine the hospital's total allowable cost (TAC).

2. The number of Medicaid recipient inpatient days of stay served by the routine and special care unit costs including nursery days will be determined (MAD).

3. Title XIX per-diem will be determined using the formula:

$$\text{XIX Per Diem} = \frac{\text{TAC}}{\text{MAD}} \text{ ; and}$$

4. A one percent intensity allowance will be applied to all hospitals for fiscal year 1985 and 1986.

B. The Title XIX per-diem as determined and adjusted according to paragraph III.A.1.-4. will be adjusted by the indices for the hospital industry for the applicable hospital fiscal years.

C. Nursing Salary Cost Differential

Title XIX reimbursement will not recognize the above average cost of inpatient routine nursing care furnished to aged, pediatric, and maternity patients. The inpatient routine nursing salary cost differential reimbursed by the Title XVIII program will reduce the reasonable cost for determining Title XIX reimbursement as required in the applicable HCFA cost reporting forms for periods prior to October 1, 1982. Due to deletion as a Title XVIII allowable cost, for periods forward from October 1, 1982, the inpatient routine nursing cost differential will not reduce the reasonable cost for determining Title XIX reimbursement.

D. Malpractice Insurance Premium Costs. The portion of a facility's total hospital malpractice insurance premium cost that is allowed per Medicare principles as administrative and general costs is an allowable cost for calculating a facility's Medicaid rate. If a facility's cost report has been filed or adjusted to reflect a division in its malpractice insurance premium cost between administrative and risk per Medicare principles and Medicare's share of the risk portion is calculated using the scaling-factor, Medicaid's share will be determined as follows:

1. The hospital's and subproviders' total charges (TCHS) are determined as follows:

   A. Charges for all provider types other than hospital and subproviders (Supplemental Worksheet D-8, Part II and/or Worksheet G-2) are subtracted from total patient revenue (Worksheet G-2).

2. The total Medicaid charges for inpatient and outpatient services (TMC) as determined by desk review of the cost report.

3. Medicaid's malpractice ratio (MMR) is determined using the following formula: $\frac{TMC}{TCHS} = MMR$

4. The risk portion to be allocated (RPA) is determined as follows:

   A. Risk portion of premium is obtained from Supplemental Worksheet D-8, Part I, line 3;

   B. Subtract the allocated premiums on Supplemental Worksheet D-8, Part II, Column 3, for any additional provider types other than hospital and subproviders.

5. Medicaid's share (MS) of the Risk portion is determined using the following formula:

   $$MS = RPA \times MMR$$

6. Allocation of Medicaid's malpractice cost between the inpatient and outpatient programs will be based on a ratio of each program's Medicaid allowable charges to total Medicaid allowable charges.

IV. Exemptions - New Hospitals

A. Facilities Reimbursed by Medicare on a Per-Diem Basis

In the absence of adequate cost data, a new facility's Medicaid rate may be its most current Medicare rate on file at the time of the semi-annual rate determination and review on June 15 and December 15 for two (2) fiscal years following the facility's initial fiscal year as a new facility. The Medicaid rate for this third fiscal year will be the lower of the most current Medicare rate on file by review date or the facility's Medicaid rate for its second fiscal year indexed forward by the inflation index for the current fiscal year. The Medicaid rate for the facility's fourth fiscal year will be determined in accordance with sections I.-III. of this plan.

B. Facilities Reimbursed by Medicare on a DRG Basis

In the absence of adequate cost data, a new facility's Medicaid rate may be one hundred twenty percent (120%) of the average weighted, statewide per-diem rate for two (2) fiscal years following the facility's initial fiscal year as a new facility. The Medicaid rate for the third fiscal year will be the facility's Medicaid rate for its second fiscal year indexed forward by the inflation index for the current fiscal year. The Medicaid rate for the facility's fourth fiscal year will be determined in accordance with sections I.-III. of this plan.

C. Change of ownership and/or management does not create a new hospital for the purpose of exemption from the provisions of this rate reimbursement plan.

V. Administrative Actions

A. Cost Reports

1. Each hospital participating in the Missouri Medical Assistance Program shall submit a cost report in the manner prescribed by the state Medicaid agency. The cost report shall be submitted within five (5) calendar months after the close of the reporting period. The period of a cost report is defined in 42 CFR 413.24 (f). A single extension, not to exceed thirty (30) days, may be granted upon request of the hospital and the approval of the Missouri Division of Medical Services when the provider's operation is significantly affected due to extraordinary circumstances over which the provider had no control such as fire or flood. The request must be in writing and postmarked prior to the first day of the sixth (6) month following the hospital's fiscal year end.

2. The termination of or by a hospital of participation in the program requires that the hospital submit a cost report for the period ending with the date of termination within five (5) calendar months after the close of the reporting period. No extension in the submitting of cost reports shall be allowed when a termination of participation has occurred. The payments due the hospital shall be withheld until the final cost report is filed with the Division of Medical Services.

3. All cost reports shall be submitted and certified by an officer or administrator of the provider. Failure to file a cost report within the period prescribed in this subsection may result in the imposition of sanctions as described in 13 CSR 40-3.030.

B. Records

1. All hospitals are required to maintain financial and statistical records in accordance with 42 CFR 413.20. For purposes of this plan statistical and financial records shall include beneficiaries' medical records and patient claim logs separated for inpatient and outpatient services billed to and paid for by Missouri Medicaid (excluding cross-over claims), respectively. All records must be available upon request to representatives, employees, or contractors of the Missouri Medical Assistance Program, Missouri Department of Social Services, General Accounting Office (GAO), or the United States Department of Health and Human Services (HHS). The content and organization of the inpatient and outpatient logs shall include the following:

   (a) A separate Medicaid log for each fiscal year must be maintained by either date of service or date of payment by Medicaid for claims and all adjustments of those claims for services provided in the fiscal period. Lengths of stay covering two (2) fiscal periods should be recorded by date of admission;

   (b) Data required to be recorded in logs for each claim includes:

      (1) Recipient name and Medicaid number;

      (2) Dates of service;

      (3) If inpatient claim, number of days paid for by Medicaid, classified by general, newborn or specific type of intensive care;

(4) Charges for paid inpatient days or allowed outpatient services, classified by cost center as reported on cost report, except that allowed outpatient services may be recorded in the aggregate;